Return this
form to:

MEDICAID QUARTERLY REPORT

Utah-DOH-BES 24 30 229
Form 632-T , 1940 Page 1
10/00

If address or phone number has changed, cross out old information and write in new address and phone number. Please provide us with verification of your new address.

Complete this report for the months of________________
Your report must be completed by the______ of_________.
You may call ________________________ for help with this form.

Name:
Mailing
Address:

Return this form to:

You must verify all earnings and child care expenses for the 3 months listed above by the 17th of next month.. We need this information to see if you are still eligible for the 12 month Transitional Medicaid Program. **IF we do not receive this information by the 17th of next month, YOUR CASE WILL BE CLOSED.**

I. HOUSEHOLD COMPOSITION

Has anyone moved in our out of your household since your last report?: . . . . G Yes G No
If yes, please explain____

II HEALTH INSURANCE CHANGES

Has their been any changes in your health insurance coverage?: . . . . G Yes G No
If yes, please explain____

III EARNED INCOME AND EXPENSES

Please complete the information below and **verify** your income and child care expenses for the 3 months listed.

Name of Employed Person	**Name of Employed Person**
Month ______________ Child Care Expenses_________	**Month _________________ Child Care Expenses_________**
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Month ______________ Child Care Expenses_________	**Month ______________ Child Care Expenses_________**
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date_____________ Amount $ _________	Check Date____________ Amount $ _________
Month ______________ Child Care Expenses_________	**Month ______________ Child Care Expenses_________**
Check Date____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date____________ Amount $ _________	Check Date____________ Amount $ _________
Check Date____________ Amount $ _________	Check Date____________ Amount $ _________

If you do not have earned income in any of the three months, please explain why. ____
____.

IMPORTANT NOTICE CONCERNING YOUR BENEFITS

You are currently receiving Twelve Month Transitional Medicaid. In order to continue receiving Medicaid under this program, you must verify your earnings and child care expenses for the months listed on the other side of this notice. We must have this information by the 17th of next month or your Medicaid case will be closed.

EXAMPLE: For a report mailed on June 22, you would need to verify your income and child care expenses for April, May, and June. The verifications must be turned in by the 17th day of July. If the verifications are not returned by July 17th, your medical assistance would be closed at the end of the month.

Please complete the form on the other side of this notice and return it along with the verification of your earnings and child care expenses to the return address printed on the form.

You will receive a full twelve months of Medicaid coverage under the Twelve Month Transitional Medicaid program as long as you meet all of the following requirements:

A. You continue to have a dependent child in your home.
B. You continue to reside in the state of Utah.
C. You comply with the income reporting requirements.
D. You have earnings or have good cause for no earnings in each month of the three report periods.
E. Your average countable earnings do not exceed the income limit for your household size in the second and third report periods. (185% of the Federal Poverty Limit)

If you have any questions about your case, contact us at the phone number listed at the top of the report form.

You are only required to verify your income and child care expenses for Transitional Medicaid; however, please remember that you are still required by law to report changes in your situation within 10 days of the day you learn of the change. Do not delay reporting changes. Changes can effect the amount of your benefits or your eligibility. If you receive more than you are eligible to receive, you will have to repay that amount.